C+D
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8 May 2010

The stock shortage puzzle

"No big-bang solution" warns AAH boss page 10

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Are you ready for the hayfever season?

PRESCRIBING INFORMATION
Fexofenadine Hydrochloride
Telfast 120mg film-coated tablets
Presentations:
The tablets are film-coated peach coloured tablets containing 120 mg fexofenadine hydrochloride, equivalent to 112 mg of fexofenadine.
Indications:
Relief of symptoms associated with seasonal allergic rhinitis.
Dosage & Administration:
For the treatment of seasonal allergic rhinitis in adults and children aged 12 years and above, the recommended dose of fexofenadine hydrochloride is one tablet twice daily before a meal. The efficacy and safety of fexofenadine hydrochloride has not been established in children under 6 years of age.

Contra-indications:
Known hypersensitivity to any of the product's ingredients.
Precautions:
Studies in adults have shown that it is not necessary to adjust the dose of fexofenadine hydrochloride in the elderly or in renally or hepatically impaired patients. However, fexofenadine should be administered with care in these special groups.
Side effects (Please refer to the Summary of Product Characteristics for full side-effect details):
In controlled clinical trials the incidence of commonly reported adverse events observed with fexofenadine was similar to that observed with placebo. These adverse events were headache, drowsiness, nausea, dizziness, and sleep disorders or paroniria, such as nightmares. In rare cases rash, hypersensitivity reactions with manifestations such as angioedema, chest tightness, dyspnoea, and systemic anaphylaxis have also been reported.
Pregnancy & Lactation:
Fexofenadine is not recommended in pregnancy or for mothers breast-feeding their babies, due to absence of experience in this group of patients.
Legal Category: POM
Marketing Authorisation Number: PL 04425/0157
NHS Price: Pack of 30 Tablets: £ 6.23
Further information is available from Winthrop Pharmaceuticals, One Onslow Street, Guildford, Surrey, GU1 4YS.

Date of Revision of Prescribing Information: April 2009

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Adverse events should be reported and information about adverse event reporting can be found on www.yellowcard.gov.uk
Adverse events should also be reported to Winthrop Pharmaceutical UK Ltd as follows:- Email: uk-drugsafety@sanofi-aventis.com Tel. 01483 554242 Fax.:01483 554806

For further information please visit our website www.winthrop-pharma.co.uk, freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number 01483 554831. Date of Preparation April 2009 STW 374

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I spent last Friday tracking the supply chain from manufacturer to wholesaler to pharmacy shelf.

At the head of the chain, a shiny £1.5 million machine packed and labelled simvastatin tablets with clinical efficiency. The attention to detail – from laminar airflow to quality control checks – was just what you'd expect from a modern pharmaceutical manufacturer.

The wholesaler's operation was no less thorough. A highly automated process saw thousands of orders being picked and shipped with military precision ready for delivery.

And at the pharmacy, a robot dispenser demonstrated the innovation that the UK's most accessible healthcare network adds to the supply process.

It seems so easy, really: manufacturers, wholesalers and pharmacy sharing a common objective to get high quality medicines quickly to patients. So we have to wonder why the ongoing mess that is the supply chain is taking so long to resolve.

The summit on stock shortages called by the pharmacy minister in March has raised expectations of an imminent solution. But as AAH MD Mark James predicts (p10), there is little chance of a big bang solution. The fall in the pound has driven exporting – or so we're led to believe – and, until the exchange rate reverses, it looks like we're stuck with the status quo of quotas, emergency supplies and unnecessary administrative burden.

Phoenix CEO Paul Smith has called for a more robust list of drugs in short supply (p4). After all, if someone is prosecuted for exporting a medicine that has been classified as in short supply, the underlying evidence base must be capable of standing up to robust scrutiny.

In Scotland, they've gone even further. Legislation coming into force this month now forces pharmacists to "refrain" from any activities that delay or prevent patients getting their medicines (p4). But will these initiatives make a difference?

Surprisingly, and despite the parallel exporting concerns, the UK remains a net importer of medicines. But frankly, that's immaterial. As Mr James adds, if we view exporting medicines in short supply as "immoral, unacceptable and unprofessional", then it follows that importing medicines from countries that have shortages is equally so.

It's becoming increasingly clear that the solution to the supply chain problem will be neither quick nor easy. The EU's free movement of medicines just doesn't sit comfortably with an array of health systems that set their own levels of reimbursement.

Without a European-wide agreement, this game of medicines pass the parcel will continue, and someone's patient will always lack the vital drugs they need.

Gary Paragpuri, Editor

> "IT'S BECOMING INCREASINGLY CLEAR THAT THE SOLUTION TO THE SUPPLY CHAIN PROBLEM WILL BE NEITHER QUICK NOR EASY"

Wholesale chief: government must publish drug shortage list

EXCLUSIVE Phoenix chief says PSNC list does not give the whole picture of stock shortages

Chris Chapman
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Wholesaler Phoenix is putting pressure on the government over stock shortages by renewing calls for a centralised list of drugs in short supply.

Speaking exclusively to C+D, Phoenix chief executive Paul Smith said the current list of medicines in short supply kept by PSNC did not look at the whole picture, and called for the government to issue further guidance to end the drugs shortage.

He said: "The government needs to say what the shortages are, and balance it with information from manufacturers. Surely the only way is for the government to say it. Surely it can't be left to PSNC."

However, PSNC insisted its list, which is based on pharmacists' reports and compiled with the aid of supplier bodies, was a robust source of information. The list had been kept since November and had consistently shown the same products in short supply, said PSNC head of information services Lindsay McClure.

The PSNC list was backed by wholesaler body the BAPW. Executive director Martin Sawer, argued a second list would cause confusion. He said: "It would be difficult to have more than one list... the PSNC list is robust enough. It's on the ground and better than anything we've got."

AAH managing director Mark James said the issue was far too complex for a list to be developed easily. Alliance Healthcare declined to comment.

A central list of drugs in short supply was one of a raft of measures agreed at a ministerial summit on March 2 to tackle current drug supply woes.

Paul Smith: government must give further guidance to end drugs shortage

Scotland gets tough on exporters

The Scottish Government has toughened its response to the current drugs drought by amending regulations to crack down on pharmacists exporting medicines needed for NHS patients.

Regulations for Scottish pharmacies have been amended to "place an obligation" on pharmacists to "refrain from taking any action which may delay or prevent the dispensing of prescribed drugs and appliances to NHS patients".

The measures, which came into force on May 1, also empower pharmacists to discuss alternatives with prescribers when there may be "a clinically significant delay in the dispensing of those drugs".

The move comes in response to patients experiencing delays in receiving medicines caused, in part, by increased parallel exports, said Scotland's chief pharmacist Bill Scott in a letter to colleagues.

The changes were welcomed by Community Pharmacy Scotland head of corporate affairs Alex MacKinnon, who said the changes were a reminder to pharmacists who were considering exporting medicines.

He said: "This is reinforcing, to remind pharmacists their duty is to the patient, and if medicines are in short supply, it's patients in Scotland that get the medicines."

It was too early to predict how NHS boards would enforce the regulations, Mr MacKinnon added.

However, Stuart Notman, of Stuart Notman Pharmacy in Aberdeen, said the regulations were unlikely to have any impact on most pharmacists. He said: "I would think most are already doing that. If something is on short supply, we're all contacting prescribers."

Healthcare lawyer David Reissner said the regulation amendments were a "tightening up" of previous rules, and advised pharmacists to make sure they did not export a drug they were aware was in short supply. **CC**

How far have we come since the stock shortages summit?

See news feature p10

Stock shortage warning

Stock shortages could last until 2011 as the pound tries to gain in value against the euro, the British Association of European Pharmaceutical Distributors (BAEPD) has warned.

Speaking exclusively to C+D, BAEPD secretary-general Richard Freudenberg said an exchange rate of £1.20 to one euro would be a "tipping point" that would dry up possible parallel export profits, ending the cause of stock shortages. But he said current market volatility means the prospect was not yet on the horizon.

He said: "I would expect the market to be volatile until the early months of 2011... £1.20 seems to be a tough threshold for the market to breach." **CC**

RPSGB prepares next round of redundancies

Society job cuts prompted by "complete cost overhaul", says director

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The RPSGB will unveil job cuts in its finance and IT division later this month, C+D can reveal.

The latest round of redundancies comes as the Society bids to reduce costs before reforming as the new professional leadership body (PLB).

Finance director Graham Duncan was unable to confirm how many jobs will be shed, but all 25 positions in finance and IT have been examined. He said: "Everyone in commercial services [finance and IT] has been looked at. The numbers are still being looked at."

Mr Duncan added: "We're having a complete cost overhaul... there has to be further reductions in 2010. We need a reduction in terms of employee costs."

The latest redundancies follow 21 job cuts by the RPSGB last May in the museum, library and information services department.

The cost savings from these cuts did not appear in the Society's financial statement for 2009 published last week, Mr Duncan stressed.

These figures showed a £680,000 increase in RPSGB salaries and wages last year. Spending on director's basic salaries also rose £75,000 to over £800,000, the financial statement showed.

However, the figures failed to account for the departure of a director earning over £100,000 in last May's redundancies, Mr Duncan stressed.

Savings from redundancies since 2009 will only show in next year's financial statement, he added.

The measures come as the Society prepares for the loss of its regulatory role this year. This gives pharmacists a choice over whether to pay to join the organisation for the first time.

Mr Duncan said he was confident over the financial viability of the planned PLB. The Society was targeting 100 per cent retention of members. But he added: "If [membership] numbers go down then you have to adjust your costs."

Mr Duncan ruled out raising cash for the PLB with the sale of property assets including the president's Lambeth flat.

The RPSGB reported a dip of over £3.6 million in its operational surplus for 2009 last week.

Pension challenge

The RPSGB's finance boss has named reducing the pension deficit as his most pressing challenge in 2010.

The scheme, valued at over £12.2 million, was "not a danger, but a concern", he said.

Graham Duncan said: "I need to be given a chance to look at it – one of my objectives is to do that. It's my main objective."

The pension fund deficit for 2009 totalled £226,000, RPSGB figures revealed.

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Home MURs key to Parkinson's

Getting pharmacists to deliver MURs for Parkinson's patients at home may improve the number of sufferers being seen by a specialist each year.

A pilot held in nine Peak Pharmacies in Manchester showed seven out of 16 home visits resulted in referrals to specialists, GSK told C+D. Of the 34 MURs completed in store, nine Parkinson's patients were referred.

The pharmacies identified the people who could potentially benefit from the service by searching on their files for patients receiving medicines frequently used for Parkinson's Disease treatment.

Across the nine participating pharmacies, 78 were identified and 50 received MURs.

Linda Stephens, national pharmacy advisor to GSK, said she was delighted with the results. She said: "The reason we did this work in Manchester was because of the possibility of a specialist partnership between Peak Pharmacies and the advanced nurse practitioner.

Manchester pharmacies in the pilot delivered 50 MURs to Parkinson's sufferers

"We will be looking at the areas where this programme could be a good fit, and where there is a specialist service which does not think it is getting enough people."

Peak Pharmacy will use the results of the pilot to pitch for formal funding from Salford PCT to extend the service.

Daiga Heisters, national education advisor at Parkinson's UK, a partner in the pilot, said: "The pilot has shown some really promising outcomes in terms of partnership working across pharmacists and GPs, and the pharmacists involved said they feel more empowered.

"We will follow up with a selection of people who have used the service and report back on their views next month." **HF**

In brief

Error guidance delay

Pharmacists must wait for the promised freeze on the prosecution of single dispensing errors due to holdups caused by the general election, the Crown Prosecution Service has said. A spokeswoman told C+D there would be "no guidance for a couple of weeks".

OTC sales boost

OTC sales in the UK grew by 1.5 per cent in 2009, with retail sales in pharmacy worth £13.47 billion, according to Key Note's Market Report 2010. The report forecasts further pharmacy growth between 2010 and 2014.
www.chemistanddruggist.co.uk

BPH treatment licensed

GSK's Combodart, indicated for the treatment of moderate-to-severe benign prostatic hyperplasia (BPH) and reduction in the risk of acute urinary retention and BPH-related surgery, has been licensed for use in the UK.

Global sum devolved

The Department of Health has issued guidance for contractors following the devolution of the global sum to PCTs. This includes forms for contractors to use to claim for funding if the changes lead to increased wholesaler or supplier costs in a particular month.

Morphine injections case

The General Medical Council is considering the case of a GP accused of administering "inappropriate and irresponsible" morphine injections to 17 patients. It is further alleged that the doctor wrote "inaccurate and misleading" statements on death certificates for three patients.

Charity closes

The trustees of The Princes Trust Foundation for Integrated Health have decided to close the charity ahead of schedule, following the arrests of two people on allegations of fraud, one of whom was understood to be a former senior official at the foundation.
www.chemistanddruggist.co.uk

In brief

Shire deal goes live

Shire Pharmaceuticals has confirmed its medicine distribution deal has launched with effect from May 4. AAH, Alliance Healthcare and Phoenix have become exclusive suppliers of selected Shire products. **www.psnc.org.uk**

Numark discounts

Numark is set to launch a programme offering discounts on purchases such as holidays and groceries, as well as access to HR advice, legal information and a counselling service. The Choices programme will be available free to all Numark members and their immediate families from June 1. **www.chemistanddruggist.co.uk**

Boots industry address

Boots' chief executive will deliver the 2010 British Retail Consortium Annual Retail Lecture in London on May 18. Andy Hornby's speech will be titled 'Retailing... what's changed with the credit crunch?'.

Hunt begins for new NPA chief executive

Pressure for pharmacist appointment, but NPA board won't commit

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The NPA has begun the process of recruiting a new chief executive, but has not committed to appointing a pharmacist to the role.

Following a meeting of the board, NPA chairman Ian Facer told C+D: "The board discussed the matter of recruiting a new chief executive for the NPA and arrangements are being put in place for a recruitment process."

The association would not comment on the discussions held, and said it was "too early to say whether he or she will be a pharmacist". But one board member told C+D he felt strongly that the new chief executive should be a pharmacist if possible.

A C+D poll last month found over 70 per cent of readers wanted a CEO who had worked within pharmacy.

The NPA board also pledged to put pressure on the NHS prescription processing division over new sorting procedures at the meeting. The arrangements brought "yet more cumbersome bureaucracy" for pharmacists, the NPA ruled.

Ian Facer: too early to say whether the new CEO will be a pharmacist

The changes mean pharmacies have to separately sort prescription forms containing 'specials' or individual items with a net ingredient cost of £100 or more. The NPA said a small member survey had shown this would add time for pharmacists both day to day and at the month end.

Mr Facer said: "Pharmacies are increasingly busy and there is no spare time to do the job of the pricing authority for them." He said the NPA would be contacting the PPD to ask how long the arrangements would be in place and how soon it would be before their system would "finally work".

The board meeting also raised concerns about PCTs offering incentives on branded generics, a practice Mr Facer said was "raiding pharmacies for money and blowing holes in the nationally agreed frameworks".

Mr Facer was re-appointed NPA chair for a second year at the meeting.

Role for sector in mental healthcare, says Welsh group

Pharmacists should have a greater role in mental healthcare in the community and prison environment, according to a Welsh cross-party group on pharmacy.

A report from the inaugural meeting of the group, which is facilitated by the RPSGB's Welsh directorate, highlighted the role pharmacy can play in the area and identified key issues about mental healthcare.

For example, the report said the services pharmacists could provide for people with mental health issues appeared to be poorly recognised and not well integrated into models of care.

The group stressed that pharmacists could play a key role in medicines adherence, which could help to maintain the stability of people with mental health issues. It also said that there was clear potential for medicines use reviews to be targeted at mental health patients.

Paul Gimson, director of the RPSGB's Welsh directorate, said there had been a high level of debate on professional issues by the group, which brought together Welsh Assembly members and those with an interest in pharmacy.

The cross-party group will hold its next meeting in July to discuss rural health pharmacy services in Wales. **ZS**

Scots bid to cut binge drinking

Pharmacies will deliver consultations on the dangers of binge drinking under the Scottish Government's £36 million bid to tackle alcohol misuse.

Forth Valley and Grampian health boards have commissioned the alcohol interventions through local contractors.

The initiative sees pharmacists discussing drinking habits with patients and educating them on health risks.

The extent of pharmacy's role in delivering interventions elsewhere in Scotland will be determined by local health boards, which have been allocated the £36m funding to cut excessive drinking.

Health boards will work alongside local alcohol and drug partnerships to commission a range of measures to counter alcohol abuse.

A Scottish Government spokesperson said it was up to local health boards to determine how they allocated funding.

Announcing the initiative, health secretary Nicola Sturgeon said: "Brief interventions are a key part of our strategy and they're not only clinically effective but also cost effective. It's vital that we tackle Scotland's drinking culture." **HF**

How confident would you be raising drinking habits with a patient?

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Which party will do the most for pharmacy?
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Dispensary talk

Who will you vote for in the general election?

"That's the million dollar question. I have to think about what is best for the pharmacy world and what is best for me. I think I will be voting Labour as they are offering the most for pharmacy."
Andrew Mawhinney, Lloydspharmacy, Barton, Torquay

"I am not actually able to vote in the general election as I am not a British citizen. However, I can vote in the local election and I think I am going to vote yellow, as I always do."
Ulrika Dewhurst, Carter's Chemist, Islington, London

Web verdict

Conservatives 23%

Labour 25%

Liberal Democrats 35%

Other 5%

I won't vote 12%

Armchair view: The general election had yet to take place as C+D went to press. But it seems pharmacists' loyalties largely lie with the yellows.
Next week's question: How will pharmacy fare under the new government? Let us know at www.chemistanddruggist.co.uk

Pharmacy plays host to key election battle

Candidates call in on Lloyds team based in key marginal seat

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A Lloydspharmacy branch in Romsey played centre stage to one of the defining battles of the election last week when it hosted visits from Lib Dem and Tory candidates.

The Romsey and Southampton North seat has been named as a key target for the Conservatives in their bid to take power.

Caroline Nokes must take the marginal seat from the Lib Dems' Sandra Gidley – the only pharmacist in the House of Commons.

The duo met the Lloydspharmacy team in their hunt for votes where they discussed how the pharmacy is helping improve the health of local residents. The candidates were briefed on blood pressure and diabetes checks offered by the pharmacy team.

Ms Nokes praised the initiatives, but said she was most impressed by the long-standing support offered by the pharmacy.

It's in your hands: Sandra Gidley (above) and Caroline Nokes (far right) canvassed votes during Lloyds visit

"It was the long-term commitment to the community, the innovative daily blister packs, the free prescription delivery service, the support provided to care homes and the help and support to local people which impressed me," she said

Ms Gidley said she was particularly interested to discuss public health initiatives with staff.

"The challenge now is to make sure the promises in the pharmacy white paper become a reality."

To find out who triumphed in the constituency on polling day, go to www.chemistanddruggist.co.uk

Misconduct verdict in colic case

Pharmacists have been warned over unlicensed medicine supply after a baby received a potentially harmful colic remedy from a Northern Irish pharmacy.

The practice risked patient safety and must stop, said Tim Ferris, NI's statutory committee chairman.

His warning came after Jeffrey Reaney avoided a striking off over the supply of an unlicensed colic mixture at VE Reaney pharmacy, Hillsborough.

An unnamed staff member compounded and dispensed the remedy to the parents of a three-week-old baby at the pharmacy where Mr Reaney was superintendent, a PSNI disciplinary meeting heard.

The parents had asked for something to ease colic symptoms. The mixture supplied included a POM ingredient, despite the patients lacking a valid prescription. They later became alarmed after administering a dose. A friend who phoned the pharmacy on the parents' behalf was refused information, the committee heard.

A medicines inspector later found the remedy was a 10 per cent dilution of Merbentyl syrup, which is contraindicated for babies under six months. Mr Reaney accepted Merbentyl syrup was contraindicated and in this case should not have been supplied. The superintendent apologised for his misconduct.

Mr Reaney acknowledged the medicine was unlicensed and incorrectly labelled. Under medicines laws, it should have featured the patient's name, ingredients, specific dose, instructions and expiry date.

The committee accepted reassurances from NI's Department of Health that it was not generally concerned with the running of Mr Reaney's pharmacy. The committee noted Mr Reaney's previous good record and that he had reviewed SOPs since the incident.
Contributed

When neuropathic pain makes diabetes hard to bear

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Lyrica® ▼ (pregabalin) Prescribing Information
Refer to Summary of Product Characteristics (SmPC) before prescribing. Presentation: Lyrica is supplied in hard capsules containing 25mg, 50mg, 75mg, 100mg, 150mg, 200mg or 300mg of pregabalin. **Indications:** Treatment of peripheral and central neuropathic pain in adults. **Dosage:** *Adults:* 150 to 600mg per day in either two or three divided doses taken orally. Treatment may be initiated at a dose of 150mg per day and, based on individual patient response and tolerability, may be increased to 300mg per day after an interval of 3-7 days, and to a maximum dose of 600mg per day after an additional 7-day interval. Treatment should be discontinued gradually over a minimum of one week. *Renal impairment/ Haemodialysis:* dosage adjustment necessary, see SmPC. *Hepatic impairment:* No dosage adjustment required. *Elderly:* Dosage adjustment required if impaired renal function. *Children and adolescents:* Not recommended. **Contra-indications:** Hypersensitivity to active substance or excipients. **Warnings and precautions:** There have been reports of hypersensitivity reactions, including cases of angioedema. Pregabalin should be discontinued immediately if symptoms of angioedema, such as facial, perioral, or upper airway swelling occur. Patients with galactose intolerance, the Lapp lactase deficiency or glucose-galactose malabsorption should not take Lyrica. Some diabetic patients who gain weight may require adjustment to hypoglycaemic medication. Occurrence of dizziness and somnolence could increase accidental injury (fall) in elderly patients. There have also been post marketing reports of loss of consciousness, confusion and mental impairment. Cases of renal failure have been reported and discontinuation of pregabalin did show reversibility of this adverse effect. In controlled studies, a higher proportion of patients treated with pregabalin reported blurred vision than did patients treated with placebo which resolved in a majority of cases with continued dosing. In the clinical studies where ophthalmologic testing was conducted, the incidence of visual acuity reduction and visual field changes was greater in pregabalin-treated patients than in placebo-treated patients, the incidence of fundoscopic changes was greater in placebo-treated patients. In the postmarketing experience, visual adverse reactions have also been reported, most of which refer to transient vision loss, visual blurring or other changes of visual acuity. Discontinuation of pregabalin may result in resolution or improvement of these visual symptoms. Suicidal ideation and behaviour have been reported in patients treated with anti-epileptic agents. A meta-analysis of randomised placebo controlled trials of anti-epileptic drugs has also shown a small increased risk of suicidal ideation and behaviour. The data does not exclude the possibility of an increased risk for pregabalin. Patients should be monitored for signs of suicidal ideation and behaviours and appropriate treatment should be considered. Patients (and caregivers of patients) should be advised to seek medical advice should signs of suicidal ideation or behaviour emerge. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients, insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. The patient should be informed about this at the start of the treatment. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see side effects). There have been post-marketing reports of congestive heart failure in some patients receiving pregabalin. These were mostly elderly, cardiovascular compromised patients who received treatment for a neuropathic indication. Pregabalin should be used with caution in these patients. Discontinuation of pregabalin may resolve the reaction. **Ability to drive and use machines:** May affect ability to drive or operate machinery. **Interactions:** Pregabalin appears to be additive in the impairment of cognitive and gross motor function caused by oxycodone and may potentiate the effects of ethanol and lorazepam. In the postmarketing experience, there are reports of respiratory failure and coma in patients taking pregabalin and other CNS depressant medications. **Pregnancy and lactation:** Lyrica should not be used during pregnancy unless benefit outweighs risk. Effective contraception must be used in women of childbearing potential. Breast-feeding is not recommended during treatment with Lyrica. **Side effects:** Adverse reactions during clinical trials were usually mild to moderate. Most commonly (≥1/10) reported side effects in placebo-controlled, double-blind studies were somnolence and dizziness. Commonly (≥1/100, <1/10) reported side effects were appetite increased, euphoric mood, confusion, libido decreased, irritability, ataxia, disturbance in attention, coordination abnormal, memory impairment, tremor, dysarthria, paraesthesia, vision blurred, diplopia, disorientation, balance disorder, insomnia, vertigo, dry mouth, constipation, vomiting, flatulence, erectile dysfunction, fatigue, oedema peripheral, feeling drunk, lethargy, sedation, oedema, gait abnormal and weight increased. See SmPC for less commonly reported side effects. After discontinuation of short and long-term treatment withdrawal symptoms have been observed in some patients, insomnia, headache, nausea, diarrhoea, flu syndrome, nervousness, depression, pain, sweating and dizziness. Concerning discontinuation of long-term treatment there are no data of the incidence and severity of withdrawal symptoms in relation to duration of use and dosage of pregabalin (see warnings and precautions). In the post-marketing experience, the most commonly reported adverse events observed when pregabalin was taken in overdose included somnolence, confusional state, agitation, and restlessness. **Legal category:** POM. **Date of revision:** August 2009. **Package quantities, marketing authorisation numbers and basic NHS price:** Lyrica 25mg, EU/1/04/279/003, 56 caps: £64.40, EU/1/04/279/004, 84 caps: £96.60; Lyrica 50mg, EU/1/04/279/009 84 caps £96.60; Lyrica 75mg EU/1/04/279/012, 56 caps: £64.40; Lyrica 100mg, EU/1/04/279/015, 84 caps £96.60; Lyrica 150mg, EU/1/04/279/018, 56 caps: £64.40; Lyrica 200mg, EU/1/04/279/021, 84 caps: £96.60; Lyrica 300mg, EU/1/04/279/024, 56 caps: £64.40. **Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent CT13 9NJ, UK. Lyrica is a registered trade mark. **Further information is available on request from:** Medical Information Department, Pfizer Limited, Walton Oaks, Dorking Road, Walton-on-the-Hill, Surrey KT20 7NS.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to Pfizer Medical Information on 01304 616161

References: 1. Siddall PJ, et al. Neurology 2006;67(10):1792-800. **2.** Freynhagen R, et al. Pain 2005;115(3):254-63. **3.** Freynhagen R, et al. Schmerz 2006;20(4):285-92. **4.** Freeman R, et al. Diabetes Care 2008;31(7):1448-54. **5.** Sabry BR, et al. Pain Med 2008;9(8):1092-8. **6.** LYRICA®. Summary of Product Characteristics (EMEA).

Read C+D's coverage of the stock shortages summit
www.chemistanddruggist.co.uk/news

The stock shortages summit: examining the impact since March

COVER STORY Manufacturers, wholesalers and community pharmacy all signed up to measures to ease stock shortages at a summit in March, but AAH managing director **Mark James** warns it might not be all that simple

From the numerous recent conversations I have had, there is a tangible sense of expectation that the March summit hosted by the English health secretary Andy Burnham will imminently produce a solution to the problem of drug shortages.

I welcome Mr Burnham's involvement, albeit a bit late in the day, and we have seen welcome progress: there is a shared recognition of the seriousness of the problem and there is less finger pointing, which has resulted in more constructive conversations about how to tackle the problem.

But I am often asked how confident I am that the summit working group will come up with a workable solution that could be implemented quickly.

The answer is that I am optimistic the group will be able to identify useful steps that all parties concerned could take to ease the situation. But given the potential implications for both manufacturers and pharmacists, I am much more cautious about whether the group will be able to propose a big bang solution that can be implemented almost overnight.

For example, those involved in the summit and the subsequent working group – the ABPI, health departments, BAPW, PSNC and others – are discussing a proposal to produce a definitive list of products in short supply. In theory nobody should export those products as they are required for UK patients, and various professional and legal penalties have been suggested in order to make that enforceable.

But what is the definition of a product in short supply? Is it when a pharmacist has to spend an inordinate amount of time phoning emergency supply numbers to fulfil a prescription? Or does it apply when wholesalers see customer demand exceed supply from manufacturers? The criteria you use to decide which products are in short supply is critical and is not an easy question to answer. Yet it needs to be bullet proof if you intend to prosecute someone for exporting that line against the national interest and expect to get a conviction.

There are also the practical implications of products coming on the list and dropping off. We could see quotas being switched on and off, product by product, month by month. The impact of that on stock management will be, shall we say, interesting. For pharmacists and potentially the DH there could also be a significant price tag attached to a solution to end drug shortages. The health minister has described exporting from the UK medicines that are in short supply as immoral, unacceptable and unprofessional. But if you accept that is the case – and I know many people do – then it follows that importing medicines from other EU countries, where there are shortages, is equally immoral, unacceptable and unprofessional.

We could end up with the government prosecuting UK pharmacists for exporting while at the same time financially incentivising the same pharmacists to buy medicines imported from other EU countries.

If ever we do see such court cases I will be fascinated to hear the government's lawyers explain how exporting Zyprexa from the UK is worthy of criminal sanction, yet importing Zyprexa is a good thing because PIs save the NHS tens of millions of pounds each year.

We know a solution has to be found but to arrive at one we need to be realistic about the potential challenges it may pose for both manufacturers and pharmacists.

What will the solution look like and how long will it take the summit working group to draft some proposals? I do not know, but I think it will be a lot longer and more difficult than many people currently expect.

Mark James: "We could see quotas being switched on and off, product by product"

C+D would like to hear what you've got to say on issues affecting the community pharmacy sector. If you'd like to write a comment piece or just send us your thoughts, email us

zoe.smeaton@ubm.com

Your views

"I would have liked to see some improvement in the situation by now but it's worse than ever. I think the summit helped make the ministers feel better but it hasn't had any impact on the ground. I can't see a solution being found without involving the EU – this is a Europe-wide issue so we can't look at the UK in isolation."
Mike Hewitson, Beaminster Pharmacy, Dorset

"I still talk to pharmacists who are having problems obtaining stock and I can't see any quick fix for this. It has to be sorted out, but a lot of the things that came out of the summit were quite soft."
Mark Stone, Devon LPC pharmacist

Join the debate

Join in C+D's discussion on stocks on LinkedIn – a private online network where like-minded groups of professionals can share their ideas and discuss issues that affect them. To take part in our discussion:

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GSK launches soluble Solpadeine

GSK Consumer Healthcare is launching a soluble formulation of its pharmacy painkiller brand Solpadeine Max.

Solpadeine Max Soluble tablets contain 500mg paracetamol, 12.8mg codeine and 30mg caffeine and "gets to work twice as fast as ordinary paracetamol tablets", the manufacturer claims.

The launch will be supported with a PoS campaign this summer, as well as a series of educational initiatives to help pharmacy staff understand the appropriate use of codeine-containing products, GSK says.

Solpadeine Max Soluble will be available from early May, says GSK.

It is indicated for the short term treatment of acute moderate pain including migraine, dental pain, headache, period pain and backache, when other painkillers have not worked.

Prices: £3.49 (16); £5.89 (32)
Pip codes: 353-7479; 353-7461
GSK Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

Market focus

- The adult oral analgesics market is worth £211 million.
- The adult oral analgesics markets is growing 3 per cent year on year.
- Pharmacy has a one third share of the adult oral analgesics market.

Source: Kantar Worldpanel value sales, 52 weeks to November 29, 2009

Glutafin adds two products to gluten-free food range

Glutafin has added two products to its gluten-free food range.

As well as launching Glutafin Gluten Free Baguettes and Mini Crackers, the company has relaunched its Wheat Free Fibre Rolls with an improved recipe.

All three products are available for sale and on prescription.

Glutafin is supporting its whole range with an advertising campaign that it says is designed to encourage coeliacs to carry on enjoying life after diagnosis. Advertisements are appearing across magazines and online, inside hospitals and medical surgeries, and through direct mail, blog sites and social networks.

Prices: £3.59 Mini Crackers (175g); £4.26 Baguettes (2); £4.47 Wheat Free Fibre Rolls (4)
Pip codes: 353-5515; 224-0117; 344-3652
Glutafin
Tel: 0800 988 2470
www.glutafin.co.uk

ICaps relaunches as one-a-day formula with added extras

Alcon is relaunching eyecare dietary supplement ICaps as a one-a-day formula with extra lutein/zeaxanthin.

The reformulated supplement now contains 10mg lutein/zeaxanthin. Ophthalmologists consider these the most important nutrients for age-related macular problems and ocular supplementation, according to a study released last year.

The reformulation is designed to aid patient compliance, says the manufacturer, and has delayed release action for greater absorption and reduced stomach irritation.

Price: £11.99 (30)
Pip code: See C+D Monthly Price List or www.cddata.co.uk
Alcon; tel: 0800 092 4567
www.icapsinfo.co.uk

Drontal wormer campaign sees double digit sales growth

Bayer Animal Health has reported double digit sales growth for pet wormer brand Drontal.

The success follows an advertising campaign that included sponsorship of TV series The Dog Whisperer. Bayer says the campaign resulted in a 5 per cent increase in brand awareness and doubled the number of pet owners wishing to purchase Drontal products through pharmacy (Insight Track, March 2010).

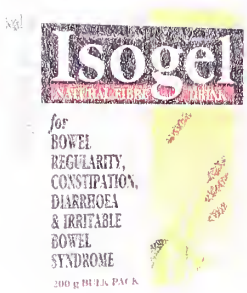
The manufacturer pledged to continue to support pharmacy through advertising and sponsorship designed to boost sales in the sector.

Prices: from £6.31
Pip codes: See C+D Monthly Price List or visit www.cddata.co.uk
www.bayerhealthcare.com

Fibre drink Isogel returns

Potters is reintroducing fibre drink Isogel "due to popular demand".

Isogel will be relaunched in selected independent pharmacies and available to buy online, after the company was "inundated" with requests following its removal from the market.



The drink combats IBS symptoms and aids healthy bowel movements, Potters says, and will be in the same formulation as previously. Isogel is taken orally twice a day by mixing the granules in water.

Price: £5.49 (200g)
Pip code: 351-5640
Ceuta Healthcare
Tel: 01202 780558
www.pottersherbals.co.uk

alli On TV next week

Flomax Relief MR: ITV, five, Sat
Lanacane Anti Chafing Gel: All areas
Nicorette Inhalator: All areas
PharmaSite for next week:
Oilatum – windows, **Oilatum** – in-store, **Oilatum** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

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*IRI HBA Outlets, Spot & Acne category, Value sales, Feb '10

For Freederm Treatment Gel and Freederm Gel only: Freederm Trademark and Product Licence held by Diomed Developments Ltd, Hitchin, Herts, SG4 7QR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ, UK. **Indications:** For the topical treatment of mild to moderate inflammatory acne vugaris. **Directions:** For adults, children and the elderly: Apply to the affected area twice daily after the skin has been thoroughly washed with warm water and soap. Enough gel should be used to cover the affected area. If there is no improvement within 12 weeks, patients should seek advice from a doctor or pharmacist. For cutaneous use. **Contraindications:** Not to be used in cases of sensitivity to any of the ingredients. **Precautions:** Not suitable for patients with severe acne. For external use only and to be kept away from the eyes and mucous membranes, including those of the nose and mouth. If excessive dryness, irritation or peeling occurs reduce the dosage to one application per day or every other day. Vitamin B derivative requirements, such as nicotinamide, are increased during pregnancy and infancy. Nicotinamide is excreted in breast milk. As with all medicines, care should be exercised during the first trimester of pregnancy. **Side-effects:** The most frequently encountered adverse effect reported is dryness of the skin. Other less frequent adverse effects include pruritus, erythema, burning sensation and irritation. **Freederm Treatment 4% w/w Gel Legal category:** P **Packs:** 25g, RSP £8.95. (£7.62 exc. VAT) PL 0173/0398 **Freederm Gel Legal category:** GSL Packs: 10g, RSP £4.99. (£4.25 exc. VAT) PL 0173/0187 **Revision Date:** March 2009.

Time to talk about dry mouth?

Approximately 20% of people suffer symptoms of dry mouth[1], primarily related to disease and medication use. More than 400 medicines are associated with dry mouth[2], especially if three or more are used together[3].

The Biotène System

The Biotène formulations supplement natural saliva, providing some of the missing salivary enzymes and proteins in patients with xerostomia and hyposalivation to replenish dry mouths.

The Biotène system allows patients to choose appropriate products to fit in with their lifestyles

Products specially formulated for dry mouth

- Biotène Oralbalance Saliva Replacement Gel – For relief of dry mouth
- Biotène Oralbalance Moisturising Liquid

Hygiene Products

- Biotène Fluoride Toothpaste
- Biotène Moisturising Mouthwash

The range is specially formulated for individuals experiencing dry mouth or related oral irritations:

- Alcohol free • Sodium Lauryl Sulfate (SLS) free • Mild flavour

The Biotène range:

- Helps maintain the oral environment and provide protection against dry mouth
- Helps supplement saliva's natural defences

biotène for dry mouth

1. Billings RJ. Studies on the prevalence of xerostomia. Preliminary results. Caries Res. 23 Abstract 124, 35th ORCA Congress 1989. 2. Eveson JW. 'Xerostomia'. Periodontology 2000. 48. 85-91. 3. Sreebny LM, Schwartz SS. 'A reference guide to drugs and dry mouth – 2nd edition'. Gerodontology 1997. 14. 1. 33-47.

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1. AC.N. total sleeping aids, value sales, MAT to w/e 20.02.10

Nytol and Nytol One-A-Night are aids for the relief of temporary sleep disturbance. **Nytol Herbal Tablets** are to soothe and so aid restful sleep. **Legal categories:** Nytol Herbal GSL, Nytol and Nytol One-A-Night P. **Further information is available** from GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K.

Nytol, Nytol One-A-Night and **Good Mornings Follow a Good Nytol** are registered trade marks of the GlaxoSmithKline Group of companies.

For consumer information, please visit Nytol.co.uk

gsk GlaxoSmithKline Consumer Healthcare

Achieving service provision on the cheap

"DOING MORE FOR LESS IS SO COMMON THAT IT SHOULD BE PART OF THE UNDERGRADUATE TRAINING"

By the time you read this, the long-awaited result should be known.

After endless speculation and media guesswork, we should finally know the answer. No – I'm not talking about whether we're governed by Red, Yellow, Blue, or some sort of muddy-brown coalition. I mean owning up about how much debt we really have, how much our income will go down, and how much our tax will go up. The country's stony broke, so the next contract negotiations could be like fighting over slices of a cake that's already been eaten.

I've been a locum, an owner/proprietor, and worked for a multiple, and there have been times in each role that I've cursed my vocation. However, despite the long hours, the workplace stress, and not being able to go to the loo without someone wanting you, it has always paid the mortgage – and for many bottles of wine – and I'm very grateful for that.

I chose my degree during a previous recession, attracted by the fact that there was no unemployment with our qualification. So my fear now is not for those of us with an MRPharmS, but for the thousands of other employees who saw their hours cut or colleagues made redundant following the profit famine caused by category M. That was bad enough, so god help us when the swingeing NHS cuts of several billion pounds come in over the next three years!

Several times recently I've read that pharmacy will be expected to do more for less. Now that's OK – doing more for less is so common that it should be part of the undergraduate training – but what I fear is that we'll see another round of businesses cutting hours or staff numbers.

Not only will this mean yet more stress and pressure, but more seriously it may lead to an inability for pharmacy to take on the new services that we so desperately need.

And what of patients in all of this? Each party leader stood at the televised debates and said spending on the NHS would be maintained, so the PCTs will still be expected to provide all the current services.

However, 'maintaining spending' doesn't mean the increasing year-on-year spending of the previous decade, and this spending freeze means that now more than ever the PCTs will be looking for cheaper ways of providing the services. And what cheaper way of doing something than asking pharmacy to do it! So as the buzz words for the coming years will be 'self-care' and 'healthy lifestyles', we should take the opportunity to tell commissioners that it's so much more cost-effective for patients to be treated for uncomplicated conditions at the pharmacy.

Whether through OTC sales or a minor ailments scheme, this could be a real opportunity for us to make a difference and get a bigger share of that smaller cake. Now, if only we hadn't got rid of the staff...

The great medicines adherence dilemma

No one really knows the extent of the medicines adherence problem. The World Health Organization (WHO) says between 30 and 50 per cent of patients do not take their medicines as directed, but this is almost certainly an underestimate as patients are prone to giving socially acceptable responses to researchers.

Non-adherence is driven by a complex web of social, psychological and cultural factors. But there are practical considerations too. Many patients feel there are too few opportunities to ask questions about the prescribed treatment at the start of their therapy.

According to a study we commissioned from the polling firm Harris, there is widespread confusion about the role of medications as well as misunderstanding about dosage, frequency, course duration and contraindications. More than six million people say they have been left bewildered and confused by the information they receive about medicines from GPs.

Quite apart from the impact on health outcomes, WHO estimates that non-adherence results in £4 billion worth of medicines being used incorrectly in the UK alone.

All pharmacists will recognise the benefits of greater patient interaction. Repeat prescription services and MURs enable pharmacists to engage in conversations that will lead to greater adherence. But ultimately we need leadership and funding from government to ensure a consistent, national approach to medicines adherence.

We have a duty to ensure patients receive sufficient information to enable the safe and effective use of the prescribed medicine, but overloading them with information can be counter-productive. Leaving a vacuum is dangerous. Patients often form their own beliefs about their medication and develop concerns about the consequences of taking it. Some will consult friends and family rather than a healthcare professional. We need to work together as a sector, and also with patient groups and government, to develop a set of guidelines to strike the right balance and so increase compliance.

There has been talk of a government-funded national medicines adherence service for some time but no firm commitment had been made before Parliament dissolved for the election campaign.

I write this before the outcome of the election is known but my message to the new government is simple. One in 10, or two million people, with chronic conditions who take medicines incorrectly end up in hospital. An adherence programme could save money and lives.

Andy Murdock, pharmacy director, Lloydspharmacy

"TWO MILLION PEOPLE WITH CHRONIC CONDITIONS WHO TAKE MEDICINES INCORRECTLY END UP IN HOSPITAL"

Update

Your weekly CPD revision guide

How diet affects cancer risk

Evidence is growing that certain foods might cause or protect against cancer

Steve Bremer MRPharmS

60-second summary

On next week's Fruit Day Friday (May 14) the cancer charity World Cancer Research Fund aims to encourage people to eat more fruit and veg. This article, which can be used for your CPD, gives evidence-based reasons to endorse the healthy diet message.

Is alcohol now considered more of a risk than previously?

There is evidence that as little as one unit a day can increase the risk of certain cancers, so some experts now recommend a limit of two units a day for men and one for women.

Why does fibre protect against bowel cancer?

Bacteria in the gut ferment fibre to produce chemicals with anti-cancer properties. Fibre also speeds transit, reducing bowel contact time with harmful chemicals.

Why might red meat be harmful?

The red pigment haem, which is found in red and processed meat, can stimulate gut bacteria to produce carcinogens.

This article (Module 1525) can help in the following CPD competencies: G1a, G1d, G1q, C2a, C2c. See http://tinyurl.com/68ox7b

Scientists estimate that 26 per cent of UK cancers could be prevented by altering diet,[1] making it second only to tobacco as a preventable cause. Despite this shocking estimate, few specific foods or drinks have been convincingly linked with cancer because of the difficulty of designing studies that accurately look at the effect of a single food.

The European Prospective Investigation into Cancer and Nutrition (EPIC) is the largest study of diet and health ever undertaken, and is currently studying the links between diet and cancer. It is a long-term prospective study of more than 500,000 healthy people in 10 European countries.

Fibre and bowel cancer

The EPIC study found that a high fibre diet can reduce the risk of bowel cancer.[2] People who ate the most fibre had a 25 to 40 per cent lower risk of bowel cancer compared with those who ate the least. Some other large studies have supported these findings.

Other studies have found that fibre does not affect bowel cancer risk, but these studies only investigated populations from single countries and may have looked at ranges of fibre that were too low. For example, Americans generally eat little fibre, so a large study focused on Americans would not reflect the benefits of the high levels of fibre that certain Europeans would eat.

Fibre could protect against bowel cancer in several different ways. For example, bacteria in the bowel interact with fibre to produce several chemicals, including butyrate, which changes conditions in the bowel so that tumours are less likely to develop. Experiments have shown that butyrate can also stop the growth of cancer cells and cause them to die.

Fermentation of fibre (non-starch polysaccharides – NSP) in the bowel produces short-chain fatty acids, which have known anti-cancer properties. Fibre also increases the weight of stools and the frequency of bowel movements, which reduces the contact time between the bowel and chemicals in the stools.

Fruit and vegetables

A diet rich in fruit and vegetables could reduce the risk of mouth, oesophageal and lung cancers, as well as some types of stomach cancer, according to EPIC. Some studies have found that people who eat the most fruit and vegetables can lower their risk of cancer by about a quarter compared with those who eat the least.

Fruit and vegetables contain anti-oxidant nutrients such as vitamin C and carotenoids, folate and a range of phytochemicals (glucosinolates, dithiolthiones, indoles, chlorophyll, flavonoids, allylsulphides and phytoestrogens). Because of this complex mixture it is still unclear which nutrients might reduce cancer risk, but it may be that a combination of nutrients is needed. One study found people who eat the widest range of fruit and vegetables have a 22 per cent lower risk of mouth cancer than those who eat the narrowest range.[3]

Vitamin and mineral supplements do not seem to have the same benefits as their naturally occurring equivalents, perhaps because of a combined effect from the vitamins and nutrients in fruit and vegetables. A Cochrane review[4] found that various supplements (beta-carotene, vitamin A, vitamin C, vitamin E and selenium) either have neutral or harmful effects.

The World Cancer Research Fund recommends that adults eat five portions of fruit and vegetables a day to lower their cancer risk. A portion is about 80g of fruit or vegetables, which is roughly equal to:

- an apple, orange or banana
- a handful of grapes or berries
- a tablespoon of raisins or other dried fruit
- two serving spoons of cooked vegetables eg broccoli or carrots
- two serving spoons of beans and pulses (only one portion per day)
- a 150ml glass of fresh fruit juice or smoothie (only one portion per day).

Beans and pulses only count towards one portion per day because they are high in fibre, but don't contain the same balance of nutrients as other fruit and vegetables. And fruit juice only counts as one because it is high in nutrients but low in fibre.

Red and processed meat

Eating a lot of red or processed meat increases the risk of bowel cancer, according to a meta-analysis of prospective studies.[5] It concluded that eating an additional 120g of red meat daily increases the risk of bowel cancer by around 25 to 35 per cent, and the risks are higher per gram of processed meat. There is also growing evidence linking red meat to pancreatic and stomach cancer.

A red pigment called haem is thought to be what links red and processed meat to bowel cancer. Haem could stimulate gut bacteria to produce N-nitroso compounds (NOCs), many of which are known to cause cancer. It may also

irritate or damage cells in the bowel, triggering cell proliferation. The way meat is cooked may also influence the cancer risk. Cooking meat at high temperatures, eg frying or barbecuing, produces heterocyclic amines, which can damage DNA.

Obesity

Many types of cancer, including two of the most common and three of the hardest to treat, are more common in people who are overweight or obese. These include:

- breast cancer, in post-menopausal women
- bowel cancer
- endometrial cancer
- oesophageal cancer
- pancreatic cancer
- kidney cancer
- gallbladder cancer.

Fat tissues in overweight people produce more hormones and growth factors, including oestrogen, which increases the risk of certain cancers such as breast cancer. Fat stored around the waist is particularly likely to encourage the body to produce growth hormones, high levels of which are linked to increased cancer risk.

Alcohol

There is no doubt that alcohol can cause seven types of cancer, with risks much greater among smokers. Alcohol causes around 6 per cent of cancer deaths in the UK every year, killing over 9,000 people. Risk of cancers of the oral cavity, oesophagus, larynx and pharynx increases linearly with quantity of alcohol consumed above 25g a day (8g of pure alcohol is about one unit). Someone drinking 100g a day has a four- to six-fold increased risk of these cancers compared with light or non-drinkers.

Smoking and drinking heavily in combination increases the risk of these cancers by up to 80 fold. And long-term heavy alcohol consumption increases the risk of liver cancer, with a five-fold increase in risk for people drinking more than 80g a day for 10 or more years.

The risk of breast cancer increases by around 7 per cent for every additional 10g a day of alcohol. This link is probably mediated by an increase in oestrogen levels.

As little as three units per day can increase the risk of mouth, throat, oesophagus, breast and bowel cancers. Research shows that the total amount of alcohol drunk over time is the most important factor, rather than when or how it is drunk. All types of alcohol increase cancer risk, regardless of whether it is beer, wine or spirits.

There are various possible mechanisms for alcohol's carcinogenic effect at most sites. Acetaldehyde, the primary metabolite, has been shown to alter DNA and cause cell proliferation. Alcohol may act as a solvent for other carcinogens (eg tobacco smoke), may produce reactive oxygen and nitrogen species, and may interfere with metabolism of folate or other micronutrients.

Other dietary factors

There is some evidence that eating too much salty food, or food preserved with salt, could increase the risk of stomach cancer by causing atrophic gastritis. Salt may also interact with Helicobacter pylori (the presence of which is linked to a doubling of stomach cancer risk) in the stomach.

Table 1. Strength of evidence linking cancer types to dietary factors

Factor	Sufficient evidence	Limited evidence
Alcohol	Breast, larynx, oesophagus, oral cavity, pharynx, liver, bowel	
Fruit and vegetables	Oral, oesophagus, pharynx, larynx, stomach, lung	Bowel, bladder
Processed and red meat	Bowel	
Fibre	Bowel	
Salt	Stomach	
Saturated fat		Breast
Dairy products	Bowel	
Thermally hot food and drinks		Oral cavity, pharynx, oesophagus

Red denotes positive association (possible cause) and blue denotes negative association (protective)
Source: Cancer Research UK

Table 2: Dietary tips for lowering cancer risk

- Eat at least five different portions of fruit and vegetables every day.
- Try to eat fruit and vegetables of different colours to ensure a mixture of nutrients.
- Eat smaller and fewer portions of red and processed meat.
- When you do cook red and processed meat, use low temperature methods such as braising.
- Boost fibre intake by choosing wholegrain varieties of starchy foods, such as wholemeal bread.
- Cut down on saturated fats as contained in fatty meat, biscuits, crisps, cheese and butter.
- Limit daily alcohol intake to two units for men and one for women (one unit = half a pint of normal strength beer or lager, or a 125ml glass of wine or a pub measure of spirits).
- Maintain a healthy body weight.

Dairy products have been shown to lower the risk of bowel cancer because of the calcium and vitamin D they contain, although the mechanism remains unclear.

Scares linking artificial sweeteners to cancer were based on flawed studies and effects that are specific to rats. Large studies in humans have provided strong evidence that artificial sweeteners are safe for humans.

Some studies have found that green tea could reduce the risk of breast, prostate, oral, oesophagus, stomach and bowel cancers. Green tea contains high levels of catechins (three to 10 times more than black tea). These catechins prevent DNA damage by mopping up free radicals, blocking the growth of tumour cells and stopping the activation of cancer-causing chemicals. More evidence is needed from large scale studies to prove that green tea can prevent some cancers.

One study found that men who ate two or more servings of tomato sauce each week reduced their risk of being diagnosed with prostate cancer by a third.[6] And EPIC found that people with the highest levels of lycopene (an antioxidant found in tomatoes) in their blood have lower risk of advanced types of prostate cancer, though not all studies agree on this. It is unclear how large a dose of lycopene is required to reduce cancer risk.

Studies funded by Cancer Research UK are currently investigating the links between:

- di-indolylmethane (found in broccoli) and cervical cancer
- silibinin (found in milk thistle) and bowel and prostate cancer
- resveratrol (from red grape skins) and bowel and prostate cancer.

Steve Bremer MRPharmS is a freelance writer and community pharmacist.

Further reading and references are online at www.chemistanddruggist.co.uk/update

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p21).

NEXT WEEK
Update looks at the first in a series of three articles on therapeutic drug monitoring

Nasacort's thixotropic[1], once-a-day formulation means that it stays where it's sprayed for maximum effect against hayfever symptoms – and with no strong odour or taste, patients prefer it over Beconase® and Flixonase®[2,3]. Give them Nasacort and help avoid problems whenever hayfever's around. For more information about Nasacort Allergy, and copies of training materials and point-of-sale items, please contact your local Laser Healthcare Pharmacy Business Manager or call 01202 780558.

Contains triamcinolone acetonide

Stays where it's sprayed

NASACORT ALLERGY NASAL SPRAY (TRIAMCINOLONE ACETONIDE) PRESCRIBING INFORMATION

Presentation: 20 ml bottle, providing 30 actuations containing 55mcg triamcinolone acetonide per metered dose. **Indications:** Treatment of the symptoms of seasonal allergic rhinitis. **Dosage and Administration:** *Patients aged 18 years and over:* The recommended dose is 220 micrograms as 2 sprays in each nostril once daily. Once symptoms are controlled patients can be maintained on 110 micrograms (1 spray in each nostril once daily). The minimum effective dose should be used to ensure continued control of symptoms. Medical advice should be sought if symptoms worsen or persist after 14 days treatment. **Contraindications:** Hypersensitivity to the active substance or excipients, infection in the nose. **Precautions and Warnings:** If adrenal function may be impaired, take care when transferring patients from systemic steroids. Localised infections of the nose and pharynx with Candida albicans has rarely occurred. Following recent nasal surgery or recent prolonged nose bleeds or any other nasal problems patients should consult their doctor before use. Treatment with high doses may cause adrenal suppression Not recommended under 18 years. Not to be used for longer than 3 months without consulting a doctor. **Interactions:** No interactions known. **Pregnancy and Lactation** Should not be administered during pregnancy or lactation unless therapeutic benefits outweigh the potential risk to the foetus/baby. **Adverse Reactions:** The most commonly reported adverse reactions are rhinitis, headache and pharyngitis. *Respiratory disorders:* epistaxis, nasal irritation, dry mucous membrane, naso-sinus congestion and sneezing; rarely, nasal septal perforations. In clinical trials these adverse reactions with the exception of epistaxis, were reported at approximately the same or lower incidence as placebo treated patients. Skin or subcutaneous disorders: rarely allergic reactions including rash, urticaria, pruritus and facial oedema. Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. **Retail Price:** 30 metered dose bottle £9. **Legal Category:** P. **Marketing Authorisation Number:** PL 04425/0605. **Refer to Summary of Product Characteristics for full prescribing information. Further information is available from the Marketing Authorisation Holder:** Medical Information Department, sanofi aventis, One Onslow Street, Guildford, GU1 4YS. Tel: 01483 505515. **Date of Revision of Prescribing Information:** April 2010.

Information about adverse event reporting can be found on www.yellowcard.gov.uk Adverse events should also be reported to the sanofi-aventis drug safety department on 01483 505515.

References: 1. Nasacort Summary of Product Characteristics, October 2008. **2.** Lumry W et al. A comparison of once-daily triamcinolone acetonide aqueous and twice-daily beclomethasone dipropionate aqueous nasal sprays in the treatment of seasonal allergic rhinitis. Allergy Asthma Proc 2003;24(3):203-10. **3.** Stokes M et al. Evaluation of patients' preferences for triamcinolone acetonide aqueous, fluticasone propionate, and mometasone furoate nasal spray. In patients with allergic rhinitis. Otolaryngol Head Neck Surg 2004; 131(3):225-231.

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How diet affects cancer risk

How might a high fibre diet help reduce the risk of bowel cancer? Which types of cancer are more common in people who are obese? What percentage of cancer deaths are alcohol related?

This article discusses the effect of diet on cancer risk. It includes information on how fibre, fruit and vegetables, red and processed meat, alcohol and obesity might increase or decrease the risk of getting certain cancers.

- Find out more about the EPIC study and the links between diet and cancer on the Cancer Research website at http://tinyurl.com/diet-cancer-1.
- Read more about other dietary factors such as acrylamide, artificial sweeteners, soy and green tea on the Cancer Research website at http://tinyurl.com/diet-cancer-2.
- Read the dietary advice and the information for professionals on the World Cancer Research Fund website at http://tinyurl.com/diet-cancer-3. Think how you could use this information when advising patients. Print out any leaflets that might be useful.
- Update your knowledge of cancer statistics in the UK on the Cancer Research website at http://tinyurl.com/yaqw3n8.

Are you more aware of the evidence-based links between diet and cancer? Could you explain them to patients and give advice about how a healthy diet could reduce cancer risk?

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Practical Approach

Coping with jet lag

Gary Hyland, a young professor of physics, and his family have occasional prescriptions dispensed and buy their home medicines at the Update Pharmacy. One day professor Hyland asks to speak to pharmacist David Spencer.

"I was wondering if you can give me some advice about jet lag?" he says when David comes out to see him. "I do a lot of travelling to international conferences and meetings, and I often find that I can't get off to sleep in the first place and then can't stay asleep. Of course, the next day I feel really washed out and have trouble staying awake. Once or twice I've actually dozed off in a meeting and it's really embarrassing. I wonder if there's anything I can get from you, or would I need to see my GP for a prescription?"

"You know about melatonin, I suppose?" David asks.

"Yes, but I've never tried it. To be honest, I don't really trust the quality of those alternative medicine products. Are there any licensed medicines containing melatonin that I could buy?"

Questions

1. What is melatonin and what is its function in combating jet lag?
2. Is melatonin an effective treatment?
3. Could professor Hyland obtain a licensed medicine containing melatonin for jet lag?
4. What other drugs are used to treat jet lag?

Answers

1. Melatonin is a hormone produced in the pineal gland. It is secreted for about 10 to 12 hours at night. Its secretion is stimulated by the dark and inhibited by light. It regulates the sleep-wake cycle by chemically causing drowsiness and lowering body temperature. Travelling from east to west extends daytime length, but the body's circadian clock has a natural cycle of about 25 hours and can adapt to extended daylight more easily than shortened day length from travelling west-east. It is thought that travellers can adapt naturally to westward travel through up to five time zones. Taking melatonin resets the body's circadian clock and induces sleep outside the normal sleep period.

2. Yes. A Cochrane review has stated: "Melatonin is remarkably effective in preventing or reducing jet lag, and occasional short-term use appears to be safe. It should be recommended to adult travellers flying across five or more time zones, particularly in an easterly direction, and especially if they have experienced jet lag on previous journeys. Travellers crossing two to four time zones can also use it if need be."[1]

3. Yes. Circadin is a prolonged-release tablet containing melatonin 2mg. However, it is a POM and only licensed for the treatment of insomnia for those aged over 55 or under 18 years. Professor Hyland's GP would be assuming personal clinical responsibility in prescribing Circadin for jet lag.

4. Hypnotics such as zolpidem have been prescribed. Slow-release caffeine 300mg has been trialled as a stimulant. Modafinil, indicated for treatment of narcolepsy and sleep apnoea, might also be effective.[2]

References

1. Herxheimer A, Petrie KJ. Melatonin for the prevention and treatment of jet lag. Cochrane Database of Systematic Reviews 2002, Issue 2.
2. Sack RL. Jet Lag. NEJM 2010; 362:440-447.

This article can help with these CPD competencies: G1a, G1c, G1d, G2o, C1a, C1f.
See http://tinyurl.com/68ox7b

To see the full archive of Practical Approach articles go to **www.chemistanddruggist.co.uk/practicalapproach**

Your guide to the GPhC draft pharmacy standards

Pharmacy's future regulator the GPhC has launched a second standards consultation – **Hannah Flynn** explains what this means for you

What are the GPhC standards?
The standards of the General Pharmaceutical Council (GPhC) will set out the requirements for pharmacists, pharmacy technicians and registered pharmacy premises, against which the GPhC will regulate the profession when it takes over the regulatory role of the Royal Pharmaceutical Society of Great Britain (RPSGB).

The standards are largely based on, and will replace, the familiar RPSGB Code of Ethics, as well as other professional guidelines, with a single set of rules for the future regulatory body to implement.

What's happening now?
The GPHC has launched a public consultation on its revised draft standards. It has already completed an initial public consultation on the first draft of the standards, the results of which were published in March.

Why is a second consultation necessary?
Responses to the first public consultation were critical of the original draft standards. Some of the issues raised were:

- respondents found the wording confusing, ambiguous, inconsistent and repetitive
- the standards focused too much on pharmacists in public-facing roles
- there was not enough evidence to support the changes being proposed.

There were also several controversial issues raised, including the so-called "conscience clause" that would allow pharmacists to refuse to provide certain services on moral or religious grounds. And nearly 60 per cent of respondents wanted a ban on self-selection of P medicines, which was proposed in the original draft.

The GPhC has now revised the draft and is undertaking the second public consultation to tackle the issues raised.

What's different about the revised version of the draft standards?
Not a lot, substance-wise. But some parts have been redrafted to reflect the criticism about the accessibility of the first draft. The main changes are to the consultation document explaining the standards, the GPhC says, "in terms of plain English and reducing duplication".

The GPhC has also promised guidance on how some of the more controversial standards, such as on the conscience clause, may be met.

The standards being consulted on cover:

- **Conduct, ethics and performance**

This includes a requirement for pharmacists to tell "the relevant people or authorities" if the pharmacist's religious or moral beliefs prevent him/her from providing a service, and to refer customers to other providers of that service. This standard has seven subsections.

Back to the drawing board: the GPhC has revised the standards it will regulate pharmacists against

- **Continuing professional development (CPD)**

This includes a requirement for every pharmacist and pharmacy technician to make a minimum of nine CPD record entries a year. It also requires a record of how CPD has contributed to the quality and develoment of your practice.

- **Superintendent pharmacists, pharmacy owners, and other pharmacy professionals in positions of authority**

This includes standards relating to the role of the responsible pharmacist, such as ensuring clear lines of accountability exist and that there are policies for the number of staff employed and their level of training.

- **Initial education and training of pharmacy technicians**

This includes a requirement for all trainee pharmacy technicians to have "access to" pharmacists and/or pharmacy technicians who are able to act as role models and provide professional support and guidance. Trainees must also be taught professional conduct and what constitutes acceptable and unacceptable practice.

How do I respond to the consultation?
Pharmacists are able to respond online at tinyurl.com/gphcstandards2.

Alternatively, they can email or post their views to the GPhC at the following addresses:

- standards@pharmacyregulation.org
- Draft Standards, Consultation Response, General Pharmaceutical Council, 129 Lambeth Road, London, SE1 7BT.

Pharmacists have until Friday May 28 to comment on the revised draft standards.

What happens after the consultation closes?
The responses to the consultation will be analysed, and a report produced for the GPhC Council, which will agree any changes before the standards for the future regulator are finalised. Once that happens, the GPhC can formally take over the RPSGB's regulatory role, which was due to happen on April 1. The GPhC has said it is "resisting the temptation to speculate" about a revised launch date.

The GPhC has promised "a range of communications activity" to make registrants aware of the new standards. GPhC staff will also be trained against the new standards, particularly those in disciplinary roles such as the Fitness to Practise Committee and inspectors.

Will these standards be here to stay?
Some of them will, at least for the foreseeable future. But those relating to superintendents and pharmacy owners and to CPD are intended to be "interim" standards that will be looked at again after the GPhC is up and running. There is no timetable for these further changes yet, but the GPhC has promised that it would not be "tinkering or meddling with things in an uncontrolled way".

The GPhC has also promised to publish plans for "an extensive standards development programme", setting out how it will take forward some of the issues raised in the consultation process so far. There are plans to consult on standards for the initial education and training of pharmacists later this year, and standards for proficiency and the return to practice policy at a later date.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on the proposed professional standards

REFLECT	Do I understand the GPhC standards and how they could change regulation?
PLAN	Read the GPhC's revised draft standards
ACT	Respond to the consultation
EVALUATE	Do I understand how the GPhC standards could change my practice?

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C+D AWARDS 2010

ETHICAL DILEMMA

This series aims to help you make the right decisions when confronted by an ethical dilemma. Every month we present a scenario likely to arise in a community pharmacy and ask a practising pharmacist and/or a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **haveyoursay@chemistanddruggist.co.uk**

Should drugs be on offer?

The dilemma

Are pharmacists shopkeepers or healthcare professionals, ie should they promote two for one offers on medicines that people use regularly or should they use professional control to limit what people can purchase?

When resale price maintenance for medicines came to an end in 2001, the longstanding restrictions on price competition for OTC medicines were lifted. This meant multi-buy offers were possible.

Sales of non-prescribed medicines from pharmacies should comply with the Code of Ethics and supporting documents. The Professional Standards and Guidance for the Sale of Medicines states that a pharmacist "must take steps to promote the wellbeing of patients, in particular children and other vulnerable individuals" and "must seek to ensure safe and timely access to medicines and take steps to be satisfied of the clinical appropriateness of medicines supplied to individual patients".

On advertising, the guidance states: "Consideration should be given to what creates a professional image in the eyes of the general public. The style, presentation and content of the advertisement need to be considered." The section on medicines promotion states: "Pharmacies may advertise the prices at which they sell medicines (subject to any legal restrictions) including any discounts offered. However, medicines are not ordinary items of commerce and there is a professional responsibility to ensure that promotions emphasise the special nature of medicines and do not encourage inappropriate or excessive consumption."

Promotions involving P medicines need to be considered on their merits, taking into account the product, pack size, conditions to be treated and the intended recipient. Pharmacists must judge where to draw the line, eg a three for two promotion on kaolin and morphine mixture is unlikely to be justifiable, but a similar promotion on a small pack of an antihistamine, where the patient is likely to need the medicine for an extended period, may well be acceptable.

Advertising can both inform the public and influence their purchasing patterns. Three for two offers are a form of advertising designed to increase or perhaps to shift the purchasing pattern so that more purchases are made from the advertiser than from other outlets.

The Medicines and Healthcare products Regulatory Agency (MHRA) is concerned that volume- based price promotions could undermine the intention of the legislation on pack size restrictions. This was intended to reduce impulsive overdoses associated with stockpiling of medicines in the home. The MHRA suggests that all persons responsible for approving price promotions for medicinal products should take into consideration consumer safety.

This is a classic issue in health ethics – balancing beneficence (acting in the best interests of others, doing good) with autonomy (maximising the freedom of an individual or community to make reasoned choices). According to the National Pharmacy Association, all healthcare professionals are struggling to find the middle ground between professional control and informed consumerism.

Jon Merrills BA (Law), FRPharmS is a pharmacist, barrister and a member of PLEA

A legal standpoint

According to reports on its website, in 2005 the MHRA upheld complaints against two retailers (Superdrug and Boots) that were running promotions on analgesics. The MHRA was concerned that such promotions could lead to stockpiling of medicines and the companies agreed to withdraw the promotions.

However, there is no legal reason why retailers cannot run certain promotions on analgesics, as the recent Poundland case shows, where it was offering three packs of paracetamol (a total of 48 tablets) for £1. Although the maximum individual GSL pack size is 16 tablets, it is not unlawful for a retailer to sell three packs at a time. There is, though, a non-binding code limiting the number of packs of certain analgesics that can be sold at any one time and the DH has regularly threatened new laws if retailers do not comply.

Noel Wardle is a solicitor with Charles Russell LLP, specialists in pharmacy law

More dilemmas are online at www.chemistanddruggist.co.uk/ethicaldilemma

CPD Reflect • Plan • Act • Evaluate

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PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement
www.wingfieldworks.co.uk/plea/index.html

Next month's Ethical Dilemma: Prescriptions from overseas

We need more Ethical Dilemmas. If you have an interesting scenario that you can share with your fellow pharmacists, get in touch via haveyoursay@chemistanddruggist.co.uk

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Alastair Buxton
Head of NHS Services, PSNC

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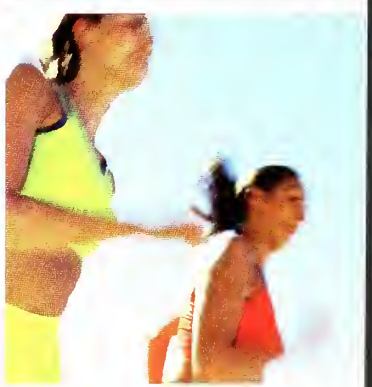

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SETTING UP A

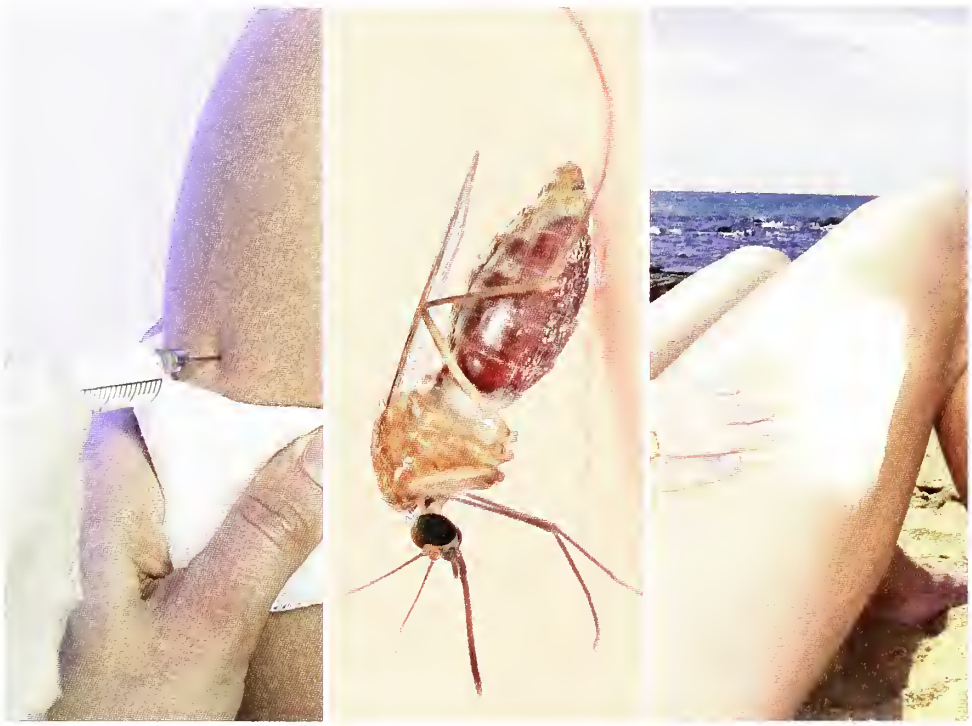
Travel health clinic

A growing number of independents and multiples have spotted the potential of travel health services. **Jennifer Richardson** looks at how can you learn from their experiences

We all dream of the perfect holiday but, in reality, the stress of organising one can leave you wondering if it's worth it. One worry you could relieve your jet-setting customers of is where to get travel health information, advice and products – generating some cash that could allow you to take a well-earned break yourself.

Scottish Borders pharmacist George Romanes believes travel health services to be a natural extension of pharmacy's role. "It's a public health role," he says. "You don't want people trailing back malaria and other things, so it's really a pharmacy issue."

And it seems the large, national multiples have spotted this potential, with Superdrug, Sainsbury's and Lloydspharmacy all having launched private travel health clinics – carrying out immunisations and advising on malarial prophylaxis – over the last two years.



Offering immunisations and advising on malarial prophylaxis could boost customer visits before their holidays

Multiple approaches

Superdrug has opted for nurse-led immunisation clinics, now in 19 stores, with their pharmacists offering travel health advice as a follow-up. And NPA information pharmacist Phil Sharratt agrees that the easiest way to run a travel health clinic from your pharmacy could be to rent out a consultation room to another healthcare professional, though he notes there are professional rewards to be had by delivering the service yourself.

The alternative is for pharmacists to undertake suitable training to provide the immunisations themselves, and this has the added bonus of skills overlap with other increasingly popular pharmacy services involving the administration of vaccines, such as flu jabs.

This is the route Sainsbury's has taken with a service that was trialled across 90 stores last summer. Roll-out has not yet been progressed, but a Sainsbury's spokesperson says it is exploring the training that will be required. "The trial was a success and it's something we want to progress but it's a completely new service that is going to require a lot of training for our pharmacists, so it's not something we can do straight away," the spokesperson explains.

And last September, Lloydspharmacy extended its online doctor initiative to travel health. Customers log onto the site, ask questions about their health and travel destination and receive information from a GP about suitable vaccines and the necessity (or not) for anti-malarials. The customer then chooses the vaccines they would like and a prescription is sent to one of 260 participating Lloydspharmacy branches, where vaccines are administered by a trained pharmacist.

Superdrug also envisages its pharmacists carrying out progressively more of the service themselves, says superintendent Martin Crisp. He hopes customers' "very, very positive" response to the travel health clinics will contribute to a "cultural change" in the public's perception of the pharmacy's role. "It's already become our biggest service," Mr Crisp says. "Hopefully that's opening the door for people to see that you can sit down in a pharmacy and for the pharmacist to become more and more involved." He adds that the service appeals to a younger clientele than Superdrug's traditional customer base – its target demographic of 18- to 45-year-olds – and that the multiple is exploring "something specific" for students.

Practical considerations

But bear in mind, warns Mr Sharratt, the demands a travel health clinic could have on a pharmacist's time. "This isn't a service you could just do ad hoc between prescriptions," he says. "Patients are going to need to be booked in and time is going to need to be spent with them."

Once you've decided on the format for

How the multiples are tackling travel health

Lloydspharmacy
Private online doctor service – the patient answers questions online, a remote GP recommends vaccines and anti-malarials where suitable, a prescription is sent to one of 260 participating pharmacies and a pharmacist administers prescribed vaccines.

Sainsbury's
Trialled private pharmacist-led travel health clinics in 90 branches last year; training to prepare for roll-out currently being explored.

Superdrug
Private nurse-led immunisation clinics in 19 branches, plus pharmacist travel health advice.

The expert view

There is an opportunity an for greater pharmacist involvement in travel health, says Professor Larry Goodyer

One of the most interesting clinical developments for community pharmacists has been in the provision of vaccination services, and a growing number have been providing influenza and HPV immunisations.

A natural extension of these activities is to provide a travel vaccination service, and there has been some very successful pilot work in Scotland on pharmacist-led travel clinics. A number of multiples as well as independent pharmacies are beginning to take an interest in what could eventually become a mainstream pharmacy activity.

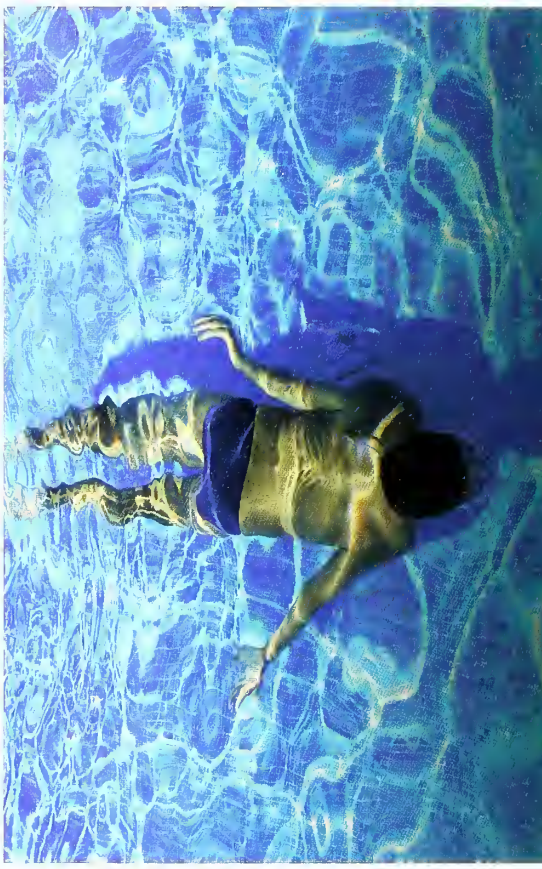
Much of travel medicine is about preparation for travel overseas by obtaining the correct advice, prophylaxis or immunisations, and health-related supplies. Arguably, community pharmacy is the ideal setting for obtaining such a public health-related service, being an accessible environment that most people will be visiting at some point before a trip overseas.

There is also an argument to be made that travel medicine should be a totally private service not funded by the NHS, and this may eventually prove to be the case.

One word of warning is that a travel medicine service is not just a question of vaccines and anti-malarial tablets but a process that involves a risk assessment and construction of a management plan for the traveller. Community pharmacists have long given advice and provided health-related supplies to travellers and a reasonable CPD plan should be sufficient for that type of provision. If embarking on a full travel medicine service through implementing PGDs or non-medical prescribing, though, a far greater level of involvement and education is required.

Pharmacist vaccination services are becoming mainstream in the US and Canada and a new initiative by the International Society of Travel Medicine (ISTM) is linking up pharmacists from around the world who have an interest and practice in travel medicine. It would be of advantage to many interested pharmacists developing an interest in this area to join and participate in the ISTM's Professional Group (PPG) of the ISTM as this will certainly link pharmacists in a wide range of resources and expertise from around the world.

Professor Larry Goodyer is head of the Worcester School of Pharmacy and a travel health expert



For further information

International Society of Travel Medicine Pharmacy Professional Group
www.istm.org

British Travel Health Association
Particularly recommended if new to the area of travel medicine
www.btha.org

The Faculty of Travel Medicine, Royal College of Physicians and Surgeons of Glasgow
tinyurl.com/cn5e6y

The Care Quality Commission
www.cqc.org.uk

The Foreign and Commonwealth Office
tinyurl.com/cds4s8

How to advise patients taking medicines abroad
tinyurl.com/medsabroad

your service, you'll need to consider its setting. As a minimum, advises Mr Sharratt, there should be a designated area for the service – a consultation or treatment room – where the customer and pharmacist can sit down. Given this, he says, and the fact that travel health consultations could be fairly lengthy, you should think about the time you can afford to give the travel health clinic in terms of the use of space also required for carrying out MURs and any other services you may run. "You'll need to balance the professional and financial return against the opportunity loss on other services," he explains.

As well as considerations such as waste disposal and sinks for your travel health clinic area, Mr Sharratt points out the necessity for online access to information resources, and anaphylactic kits. And, of course, you should have a robust business plan for the service. Mr Sharratt says: "It really is up to the individual to do their homework and ensure what they're going into is costed out correctly before they do anything."

One set-up cost could be registration with the Care Quality Commission (CQC). Pharmacists have expressed confusion about whether or not a pharmacy-based, private travel health clinic would need to be registered with the health services watchdog – and the answer is that it depends on who is administering the vaccinations and under what agreement. If a nurse or doctor is administering the vaccines, then the clinic would need to be CQC-registered, as it would if a pharmacist was carrying out the jabs under a PGD. But if the pharmacist was administering the vaccines as a pharmacist prescriber, then registration with the CC would not be required. A CQC spokesperson says: "If a provider was unsure as to whether they were required to register in order to legally provide services, then they should contact the CQC to seek clarification."

Small steps

For those not quite prepared to take the plunge of setting up a full-blown travel clinic, Mr Romanes believes he may have come up with the perfect "halfway house". His Romanes Pharmacy in Duns "takes ownership" of customers' travel health preparations, organising immunisations, and anti-malarials, but doesn't actually carry out the vaccinations itself. "People seem to appreciate that you'll take some of the stress off them and make sure they have got the right stuff," he says.

And although the service is provided free of charge, this set-up reaps benefits in linked sales of insect repellents, needle kits and mosquito nets. As Mr Romanes says: "You have got to do a selling job."

Mr Sharratt agrees. It goes without saying, he says, that you would recommend your travel health clinic customers products for travel sickness, diarrhoea and vomiting, and DVT. "It's an essential part that you will be able to build into your consultation and make those link sales.

"Vaccines and anti-malarials are not the only weapons in your armoury – take a holistic view of a travel health clinic."

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on health policy

REFLECT	How can I improve my travel health service?
PLAN	Identify what services I offer now and what I want to provide
ACT	Train staff and market services to public
EVALUATE	Has the service been delivered and has it benefited the public?

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RECRUITMENT

Career news

... at the NPA

The NPA is set to hold flu vaccination training for members in England and Wales.

For the second year running, the NPA is working with flu vaccination provider The Health Station to provide training for the former's private seasonal flu vaccination service.

The course covers clinical governance and appropriate use of patient group directions, vaccination technique and management of anaphylaxis and resuscitation.

... at PPLS and Locumlink

Two of the UK's leading pharmacist locum agencies – PPLS and Locumlink – have merged, in a move the agencies claim is already leading to better services for locums and community pharmacy clients.

The agencies have more than 50 years of combined experience. PPLS general manager Mark Day Jones said: "The knowledge, experience and operational coverage of these two organisations when combined will most definitely mean that the sum of the parts will be larger than the whole.

"Already we are finding that as a single merged agency, our much larger critical mass has seen our ability to fill jobs increase significantly. This augers well for both locums and clients in the future," he added

Career ladder

... at UKCPA

The UK Clinical Pharmacy Association (UKCPA) has appointed former University of London research manager Sarah Carter as general secretary.

Dr Carter has more than a decade of experience in pharmacy and pharmaceutical public health ... was appointed from "a ... field of candidates", the ... said.

... careers question?

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CAREERS

Follow the leader

Chris Chapman shares the secrets of great leadership skills

It's one of the most important aspects of managing a pharmacy, and it's key to your success on the career ladder, but it's not taught at university. Leadership skills are essential, both in improving your pharmacy's efficiency and demonstrating that you can take on more roles and abilities.

"Most community pharmacists have leadership skills and qualities," says Fin McCaul, chairman of the Independent Pharmacy Federation. "They've got enough drive to lead a team."

The qualities of good leaders are easy to spot: they seize the initiative, leading from the front and by example, and are willing to step up and make a choice when others hesitate. But good leaders don't just have qualities; they also know the tricks of the trade that can maximise their staff's potential.

Trevor Gore, sales development controller at Reckitt Benckiser, says pharmacists should adopt what are called situational leadership techniques to deliver results. The principle is that no style of leadership is better than any other – great leaders adapt to the audience, and specifically the audience's ability to perform certain tasks.

Essentially, there are four styles of leadership: directing, where you give instruction; coaching, where instruction is given with explanation; supporting, where the leader facilitates an action; and delegating, where tasks are assigned. Great leaders choose the style right for the situation – and that could mean using different styles for the same member of staff at different times.

Mr Gore says the first step to applying this technique is to set the area of responsibility, then the measures for achieving it – each task should have a demonstrable outcome and a timeframe. Then, diagnose the staff member's level of commitment to the task and their competency.

If the member of staff is highly committed but at a lower competence level (for example, just learning a skill), directing is useful. If the person is developing competence but is not as committed, coaching may be more effective. And once a member of staff is highly competent and committed, delegation is the most appropriate style to adopt.

Great leaders adapt their techniques to the task and lead by example

And there are other tactics you can employ to your daily practice too. Shammi Radia, of Laycock Pharmacy in Hastings, says that he was able to use simple leadership techniques to turn around his pharmacy's performance in delivering MURs. Mr Radia says he had found it hard to meet the targets, so decided to make a few leadership interventions to reach the pharmacy's goals.

The first part, Mr Radia says, was to improve communication by relating information to staff in a way they could understand. He banned the word MUR, and then demonstrated what it involved.

"It was about helping staff understand what it was," Mr Radia says. "I told them to say that the pharmacist would like to speak to the patient, rather than use the term MUR. And then I sat them down and did a mock MUR."

Relating the information saw a dramatic increase in the number of MUR referrals, demonstrating the effectiveness of clear communication. But Mr Radia went further, outlining the stick in the form of why the pharmacy needed to hit the targets, but providing a carrot as well. "I put money in a pot to go out as a group if we hit 10 MURs a week. When it got to Thursday or Friday, staff would ask if we'd hit the target."

This tactic didn't just mean the team hit their targets: by putting the money aside for going out as a group, rather than an individual reward, Mr Radia helped to foster team spirit.

So being aware of your staff's needs, making sure you measure goals, and motivating staff are key ingredients of the good leadership formula. But Asif Khan, of Global Hour pharmacy in Barnsley, says the most important aspect is to act, rather than dither.

"Show decisiveness, but fairness, so staff know where you stand. Staff should know where the boundary is... but admit your failings, and learn from your mistakes."

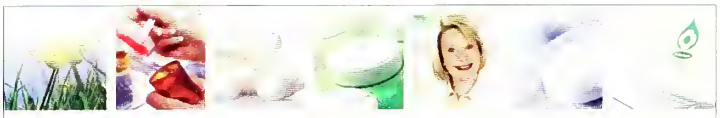
Ultimately, being a great leader is within your grasp. When it's boiled down, leadership is just about making choices and understanding your team. Pharmacists have the tools they need to be great leaders; by adopting a few simple techniques, it's easy to reap the benefits.

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on leadership

REFLECT	How good are my leadership skills?
PLAN	Identify new leadership techniques, eg in courses, books
ACT	Employ new leadership techniques in the pharmacy
EVALUATE	Have I become a more effective manager?

COURSES



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